Vision and Learning Checklist

Name	Age	Grade	Date

Your responses will help the doctor better understand your child, and address any concerns you may have in areas that could have a visual connection. Please respond to these questions using the following rating system.

4 = Always, **3** = Frequently, **2** = Occasionally, **1** = Seldom, **0** = Never

1. Do you have concerns about your child's reading abilities?
   4 3 2 1 0

2. Does your child skip lines/words when reading?
   4 3 2 1 0

3. Does your child struggle keeping their attention centered on reading?
   4 3 2 1 0

4. Does your child have better comprehension when someone reads to him or her?
   4 3 2 1 0

5. Is homework a struggle?
   4 3 2 1 0

6. Does your child have difficulty completing assignments in a reasonable amount of time?
   4 3 2 1 0

7. Do you have concerns with your child's reversals of letters/numbers?
   4 3 2 1 0

8. Do you have concerns about your child's handwriting skills?
   4 3 2 1 0

9. Does your child have frequent headaches or eye discomfort while reading or doing homework?
   4 3 2 1 0

10. Does your child have trouble with motion sickness during trips in the car?
    4 3 2 1 0

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